

2864  
Filer 9207 11-23-56 Item 17  
CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>11 Frederick</b>				c. LENGTH OF STAY IN 1b <b>4 hr.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>69 Frederick Memorial</b>				d. STREET ADDRESS <b>Boonsboro</b> 21X-2			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Carrie E. Alexander</b>				4. DATE OF DEATH Month Day Year <b>3 27 1956</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/28/1910</b>	9. AGE (In years last birthday) <b>45</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>William H. Huntsberry</b>				14. MOTHER'S MAIDEN NAME <b>Lucinda Martz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Charles E. Alexander Boonsboro Md. R.I.</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>457X Rupture of aortic aneurysm, dissecting type</b> DUE TO (b) <b>Hypertensive vascular disease</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>21 hrs.</b> <b>10 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>3/27</b> , 19 <b>56</b> , to <b>3/27</b> , 19 <b>56</b> , that I lost saw the deceased alive on <b>3/27</b> , 19 <b>56</b> , and that death occurred at <b>5:45</b> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Henry V. Chase</b> M.D.				ADDRESS (Street, city or town, state) <b>48 Church St Frederick Md</b> DATE SIGNED <b>3/27/56</b>			
PHYSICIAN'S NAME (Type) <b>Henry V. Chase</b>							
22a. BURIAL, CREMATION, REINTERMENT (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>March 29, 1956</b>		<b>Boonsboro Cemetery</b>		<b>Boonsboro Wash. Co. Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Best Funeral Home Boonsboro Md</b> ADDRESS				24a. REC'D BY REGISTRAR <b>DATE 31 March 56</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth S. Heck</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		DATE OF BIRTH [Faint text, possibly "1910-01-01"]		PLACE OF BIRTH [Faint text, possibly "Maryland"]	
RACE [Faint text, possibly "White"]		OCCUPATION [Faint text, possibly "Teacher"]		MARITAL STATUS [Faint text, possibly "Married"]		DATE OF DEATH [Faint text, possibly "1956-04-01"]	
TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF CORONER [Faint signature]		SIGNATURE OF DECEASED [Faint signature]		SIGNATURE OF WITNESS [Faint signature]	
CITY [Faint text, possibly "Baltimore"]		COUNTY [Faint text, possibly "Baltimore"]		STATE [Faint text, possibly "Maryland"]		ZIP CODE [Faint text, possibly "21201"]	

BUREAU V. S.

APR 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the information required by the law, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2865

## CERTIFICATE OF DEATH

02846

Reg. Dist. No.

131

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>11 Frederick</u>		c. LENGTH OF STAY IN lb <u>II da</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>69 Frederick Memorial Hosp.</u>		d. STREET ADDRESS <u>Rural Thurmont</u>	
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>Brice</u> Last <u>Brice</u>		4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 25. 1884</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Thurmont. Fredk Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Frank Portner</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-I4-6122</u>	
17. INFORMANT <u>Mrs Albert Misner</u>		Address <u>Thurmont. R.D. I Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis Heart Disease</u> 420.0 DUE TO <u>with congestive failure</u> (b) DUE TO <u></u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>atelectasis of left lung, cause unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/14</u> , 19 <u>56</u> , to <u>3/25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/24</u> , 19 <u>56</u> , and that death occurred at <u>3.4</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry V. Chase</u>		DATE SIGNED <u>3/24/56</u>	
PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>		ADDRESS (Street, city or town, state) <u>48 Church St. Frederick Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 27. 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>United Brethern Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Thurmont Fredk Co. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Creager</u>		ADDRESS <u>Thurmont. MD</u>	
24a. REC'D BY REGISTRAR <u>Mar 27 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Eliz. G. Heck</u>	

BUREAU V. S.

MAR 27 1956

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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

0282

DATE OF DEATH

DECEASED

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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DATE OF DEATH

PLACE OF DEATH

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Items 14 & 17 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1802847  
Film G194 3/29/56 dmr.

# CERTIFICATE OF DEATH

Reg. Dist. No. 139

2886

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY City	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X TOWN Cullen		2 days		TOWN Baltimore 3401-4			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
104 Victor Cullen State Hospital				625 S. Durham Street			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year)			
(Type or Print)		Alexander Joseph Budka		OF DEATH: March 21, 19 56			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	Married	Nov. 27, 1911	44 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Weighed trucks - State Road Comm.		Baltimore, Md.		U.S.A.			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Joseph Budka				Rose <del>Nowak</del> Nowak			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
No		None		Deceased Mrs. Bertha Budka-625 S. Durham			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Pulmonary Tuberculosis.							6 months.
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from March 19, 19 56 to March 21, 19 56 that I last saw the deceased alive on March 21, 19 56, and that death occurred at 3:00 p.m. M, from the causes and on the date stated above.							
SIGNATURE		M. D. Cullen, Md.		DATE SIGNED		March 22, 1956	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		3/24/56		Holy Rosary Cemetery		7335 Herman Hill Rd	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
3/22/56		J. J. Lynn		George A. Weber		705 S. Cum St	

RECEIVED

MAR 23 1956

BUREAU V. 1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completed certificate filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2887

## CERTIFICATE OF DEATH

02848  
Reg. Dist. No. 939

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Guilford - nr. Frederick</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS <b>Guilford - Nr. Frederick</b>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>HENRY</b> Last <b>CONLEY</b>				4. DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 7, 1876</b>		9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Medical</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles William Conley</b>				14. MOTHER'S MAIDEN NAME <b>Martha E. Larrick</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		(If yes, give war or dates of service) <b>W. War I</b>		16. SOCIAL SECURITY NO. <b>220-16-0018</b>		17. INFORMANT <b>Mrs. Charles H. Conley - Guilford - Frederick, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Congestive heart failure</b> DUE TO (b) <b>Acute myocardial infarction</b> DUE TO (c) <b>Arterio-Sclerotic heart dis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b> <b>4 yrs.</b> <b>6 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>1950</b> , to <b>20 March, 1956</b> , that I last saw the deceased alive on <b>19 March, 1956</b> , and that death occurred at <b>3:30 A. M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles H. Conley, Jr.</b> M.D.				ADDRESS (Street, city or town, state) <b>Professional Bldg</b> DATE SIGNED <b>3/21/56</b>			
PHYSICIAN'S NAME (Type) <b>Charles H. Conley, Jr., M.D.</b>				<b>Frederick, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 22</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Cline &amp; Son - Frederick, Md.</b> ADDRESS				24a. REC'D BY REGISTRAR <b>DATE 21 March 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth S. Hawk</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2888

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02849

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NE Emmittsburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARBUTUS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>A.</u> Middle <u>Gordon</u> Last <u>Cooper</u>		4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN-26-1929</u>
9. AGE (In years last birthday) <u>27</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHAUFFEUR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SO. Motor TRANSFER</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>ARTHUR B. Cooper</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>FRANCES I. Cooper</u>		Address <u>5113 ARBOTUS AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Burns entire body</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Body burnt to cinder</u> DUE TO (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>Instantaneous</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Trailer truck jack knifed &amp; caught fire</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Trailer truck jack knifed</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>1230</u> a.m. <u>  </u> p.m. <u>  </u> <u>March 6</u> 19 <u>56</u>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 97</u>	
20e. (City or town) <u>Emmittsburg</u>		20f. (County) <u>Frederick</u>	
20g. (State) <u>MD.</u>		20h. (City or town) <u>Frederick</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>B.O. Thomas</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>B.O. Thomas</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>March 6, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-9-1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>WESTERN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO.</u> <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. HOWARD STRONG</u>		ADDRESS <u>3707 W. North AVE</u>	
24a. REC'D BY REGISTRAR <u>12 1956</u>		24b. REGISTRAR'S SIGNATURE <u>L. H. Hedrick</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		RACE [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
PLACE OF DEATH [Faint text]		CITY [Faint text]	
COUNTY [Faint text]		STATE [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]	
MANNER OF DEATH [Faint text]		MEDICAL HISTORY [Faint text]	
PRESENT ILLNESS [Faint text]		TREATMENT [Faint text]	
SIGNATURE OF EXAMINER [Faint text]		SIGNATURE OF DECEASED [Faint text]	
SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF DECEASED [Faint text]	

BUREAU V. S.

MAR 12 1956

RECEIVED

ADVISORY DIVISION OF HEALTH DEPARTMENT

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

2889

02850  
Reg. Dist. No. 138

<b>1. PLACE OF DEATH</b> o. COUNTY <b>Frederick</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Frederick</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X New Market</b>			c. LENGTH OF STAY IN 1b <b>9 Years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New Market</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <span style="float: right;">First Middle Last</span> <b>BESSIE MAY COOPER</b>				<b>4. DATE OF DEATH</b> Month <b>March</b> Day <b>6</b> Year <b>1956</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>2 June 1893</b>		<b>9. AGE</b> (In years last birthday) yrs. <b>62</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Clerk</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Retail Confectionary</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>
<b>13. FATHER'S NAME</b> <b>David C. Kline</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary E. Abb</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>213-24-7891</b>		<b>17. INFORMANT</b> Address <b>Chester O. Cooper, New Market, Maryland</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>  <b>years</b>
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)							<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. <b>19</b> p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <b>1934</b> , to <b>3/6</b> , <b>1956</b> , that I last saw the deceased alive on <b>2/15</b> , <b>1956</b> , and that death occurred at <b>4:45 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>228 N. Market St., Frederick, Md.</b> DATE SIGNED <b>3/7/56</b> ACTUAL SIGNATURE <b>James B. Thomas</b> M.D. PHYSICIAN'S NAME (Type) <b>James B. Thomas</b> <b>228 N. Market St., Frederick, Md.</b> <b>3/7/56</b>							
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>10 March 1956</b>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Rocky Springs Cemetery</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Frederick County Maryland</b>		
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				<b>24a. REC'D BY REGISTRAR</b> DATE <b>MAR 9-56</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Lucian K Falcon</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02851

2890

## CERTIFICATE OF DEATH

Reg. Dist. No. 13

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>FREDERICK</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>FREDERICK</u>	
(If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		(If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>LIBERTYTOWN</u>		<u>YEARS</u>		TOWN <u>LIBERTYTOWN</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ORA</u> (Middle) <u>DELLA</u> (Last) <u>CURFMAN</u>				(Month) <u>MARCH</u> (Day) <u>7</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, SPECIFY	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>FEMALE</u>	<u>WHITE</u>	<u>WIDOW</u>	<u>12/9/1896</u>	<u>79</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
<u>HOUSEKEEPER</u>		<u>AT HOME</u>		<u>MARYLAND</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>WILLIAM E. VAN FOSSEN</u>				<u>MARY F. STAUFFER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>NO</u>		<u>R. K. CURFMAN LIBERTYTOWN MD.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
590X IMMEDIATE CAUSE (A)				<u>GOULD INFECTED</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 5, 1956</u> to <u>March 7, 1956</u> that I last saw the deceased alive on <u>March 5, 1956</u> , and that death occurred at <u>3:40 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>L. A. [Signature]</u> M. D.				ADDRESS (Street, city, town, State) <u>[Signature]</u> DATE SIGNED <u>MD.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>3/9/56</u>		<u>MTZION CEMETERY</u>		<u>MCKAIG, MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>8 March 1956</u>		<u>Elizabeth G. Heck</u>		<u>D. D. HARTZLER &amp; SONS</u>		<u>LIBERTYTOWN MD</u>	

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



# CERTIFICATE OF DEATH

Birth Date: 12/13

1. DECEASED PERSON'S NAME (Last, first, middle)

2. SEX  
 3. AGE  
 4. DATE OF BIRTH  
 5. PLACE OF BIRTH

6. OCCUPATION  
 7. MARITAL STATUS

8. CAUSE OF DEATH (Immediate)

9. CAUSE OF DEATH (Underlying)

10. PLACE OF DEATH

11. TIME OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

16. SIGNATURE OF NEXT OF KIN

17. SIGNATURE OF BURIAL OFFICIAL

18. SIGNATURE OF CORONER

19. SIGNATURE OF JURY

20. SIGNATURE OF JUDGE

BUREAU V. 2

MAR 12 1956

RECEIVED

March 12 1956

RECEIVED

1. DECEASED PERSON'S NAME (Last, first, middle)  
 2. SEX  
 3. AGE  
 4. DATE OF BIRTH  
 5. PLACE OF BIRTH  
 6. OCCUPATION  
 7. MARITAL STATUS  
 8. CAUSE OF DEATH (Immediate)  
 9. CAUSE OF DEATH (Underlying)  
 10. PLACE OF DEATH  
 11. TIME OF DEATH  
 12. SIGNATURE OF PHYSICIAN  
 13. SIGNATURE OF REGISTRAR  
 14. SIGNATURE OF WITNESSES  
 15. SIGNATURE OF DECEASED  
 16. SIGNATURE OF NEXT OF KIN  
 17. SIGNATURE OF BURIAL OFFICIAL  
 18. SIGNATURE OF CORONER  
 19. SIGNATURE OF JURY  
 20. SIGNATURE OF JUDGE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2856

CERTIFICATE OF DEATH

02852

Reg. Dist. No.

121

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) // Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) // Frederick			
c. LENGTH OF STAY IN 1b 25 years							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 209 Catoctin Avenue				d. STREET ADDRESS 209 Catoctin Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) John First Earnest Middle Dalwick Last				4. DATE OF DEATH Month 3 Day 21 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5 17 1885	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Brakeman				10b. KIND OF BUSINESS OR INDUSTRY B and O.R.R.Co		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George W. Dalwick				14. MOTHER'S MAIDEN NAME Virginia Yontz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 214-10-1615			
17. INFORMANT Mrs. Madaline Dalwick, Frederick, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion (b) Coronary Sclerosis (c) Age & Senility of Arteriosclerosis CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH 10 hrs 24 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arrhythmia & Myocardial Infarction				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 1956 to Mar 21, 1956 that I last saw the deceased alive on Mar 19, 1956 and that death occurred at 12:00 M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE A. T. BRICE M.D.				J. J. JEFFERSON MD			
PHYSICIAN'S NAME (Type) A. T. BRICE				J. J. JEFFERSON MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3-23-1956			
22c. NAME OF CEMETERY OR CREMATORY Park Heights				22d. LOCATION (City, town, or county) (State) Brunswick, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE B. L. FOSTER ADDRESS Brunswick, Maryland				24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Elizabeth G. Hicks			



## CERTIFICATE OF DEATH

02853

131

Reg. Dist. No.

2867

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>2 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt Airy</u>		d. STREET ADDRESS <u>10</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>SAMUEL</u> Middle <u>EBERT</u> Last <u>DAVIS</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>18</u> Year <u>56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 19, 1870</u>	9. AGE (In years last birthday) yrs. <u>85</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Owner</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Millard Davis</u>				14. MOTHER'S MAIDEN NAME <u>Unknown. Murphy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT Address <u>Mr. Chester M. Davis, Box #272, Carson City, Nev.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>with congestive failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 WKS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia, bilateral</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/17</u> , 19 <u>56</u> , to <u>3/18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/18</u> , 19 <u>56</u> , and that death occurred at <u>5:55A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>East Church Street, Frederick, Md.</u> DATE SIGNED <u>3/20/56</u> ACTUAL SIGNATURE <u>Henry V. Chase</u> M.D. PHYSICIAN'S NAME (Type) <u>Dr. Henry V. Chase</u> <u>East Church Street, Frederick, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 21, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>20 March 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Hesk</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2858

## CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>11 FREDERICK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK CITY</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>94 FREDERICK COUNTY HOME</b>		d. STREET ADDRESS <b>DONT KNOW</b>	
3. NAME OF DECEASED (Type or print) First <b>OLIVER</b> Middle <b>M</b> Last <b>DAWSON</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>9</b> Year <b>1956</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 27th 1881</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMING</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>LABOR</b>	9. AGE (In years last birthday) <b>74</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>E.N. DAWSON</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET E. PENN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Mrs Eula FINNEYFROCK</b>		Address <b>R.F.D. 6 Frederick Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.2 Chronic myocarditis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>2410</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1953</b> , to <b>Mar 9, 1956</b> , that I last saw the deceased alive on <b>Mar 9, 1956</b> , and that death occurred at <b>2 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H.F. Kline</b>		DATE SIGNED <b>Frederick Md. 7 Nov. 1956</b>	
PHYSICIAN'S NAME (Type) <b>H.F. KLINE Sr.</b>		<b>Frederick Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>3/12/1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet</b>	22d. LOCATION (City, town, or county) (State) <b>FREDERICK CITY MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>G.E. Barton</b>		ADDRESS <b>WALKERSVILLE MD</b>	24a. REC'D BY REGISTRAR <b>DATE 12 March 1956</b>
		24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 11



## CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH o. COUNTY <b>FREDERICK</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) p. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KEYMAR</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KEYMAR</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RURAL</b>		d. STREET ADDRESS <b>RURAL</b>	
3. NAME OF DECEASED (Type or print) First <b>PAUL</b> Middle <b>L</b> Last <b>ETZLER</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>19</b> Year <b>1956</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT 19 - 1909</b>
9. AGE (In years last birthday) <b>46</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CLAUDE R ETZLER</b>		14. MOTHER'S MAIDEN NAME <b>EDNA RIPPEON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-24-8129</b>	
17. INFORMANT Address <b>MARYLAND</b>		<b>HAZEL METZLER KEYMAR RURAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>410X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rheumatic heart disease aortic insufficiency &amp; stenosis + mitral stenosis</b> DUE TO (c) <b>15 years</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 minute</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>November, 1953</b> to <b>19 March 1956</b> , that I last saw the deceased alive on <b>19 March 1956</b> , and that death occurred at <b>2 p. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James S. Stoner, Jr.</b> M.D.		ADDRESS (Street, city or town, state) <b>Walbersville, Md</b> DATE SIGNED <b>20 March 1956</b>	
PHYSICIAN'S NAME (Type) <b>JAMES E. STONER, JR</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>3/22/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>LOCUST GROVE</b>	22d. LOCATION (City, town, or county) (State) <b>FREDERICK CO MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>D. D. Hartzler &amp; Sons Union Bridge Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 3/22/56</b>	24b. REGISTRAR'S SIGNATURE <b>Leah A. Reppe</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. BUREAU

MAR 22 1955

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02856

2892

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Emmitsburg, Md.</u>		<u>35 yrs.</u>		TOWN <u>Emmitsburg,</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>321 East Main</u>				STREET ADDRESS (If rural give location) <u>321 East Main</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Carrie</u> (Middle) <u>Emma</u> (Last) <u>Firor</u>				(Month) <u>March</u> (Day) <u>26</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Oct. 1, 1867</u>	<u>88</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own home</u>		<u>Frederick Co. Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Newcomer</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Hesser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Mrs L. Chao, D. Jellison, 321 East Main Md.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
154X IMMEDIATE CAUSE (A) <u>CARCINOMA Rectum and Kidneys</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>with generalized metastasis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 12</u> , 19 <u>55</u> , to <u>MAR 26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>MARCH 23</u> , 19 <u>56</u> , and that death occurred at <u>1:52AM</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>Charles R. Williams</u>		<u>Emmitsburg, Md</u>		<u>March 26 1956</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>March 28, 56</u>		<u>Mt. View</u>		<u>Emmitsburg, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>March 28, 1956</u>		<u>A. H. Hedrick</u>		<u>S. L. Allison</u>		<u>Emmitsburg, Md.</u>	
				<u>S. L. Allison</u>			

# CERTIFICATE OF DEATH

1900

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. DATE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. PLACE OF BIRTH

9. OCCUPATION

10. MARITAL STATUS

11. COLOR

12. EDUCATION

13. RELIGION

14. SIGNATURE OF DECEASED

15. SIGNATURE OF WITNESSES

16. SIGNATURE OF PHYSICIAN

17. SIGNATURE OF CLERK

18. SIGNATURE OF JUDGE

19. SIGNATURE OF SHERIFF

20. SIGNATURE OF CORONER

21. SIGNATURE OF JURY

22. SIGNATURE OF COURT

23. SIGNATURE OF STATE

24. SIGNATURE OF COUNTY

25. SIGNATURE OF CITY

26. SIGNATURE OF TOWN

27. SIGNATURE OF VILLAGE

28. SIGNATURE OF POST OFFICE

29. SIGNATURE OF SCHOOL

30. SIGNATURE OF CHURCH

31. SIGNATURE OF SYNAGOGUE

32. SIGNATURE OF MOSQUE

33. SIGNATURE OF TEMPLE

34. SIGNATURE OF MONASTERY

35. SIGNATURE OF CONVENT

36. SIGNATURE OF NUNNERY

37. SIGNATURE OF HERMITAGE

38. SIGNATURE OF CHAPEL

39. SIGNATURE OF ALTAR

40. SIGNATURE OF PULPIT

41. SIGNATURE OF TABERNACLE

42. SIGNATURE OF CHANCEL

43. SIGNATURE OF TRANCHE

44. SIGNATURE OF AISLE

45. SIGNATURE OF NAVE

46. SIGNATURE OF QUORE

47. SIGNATURE OF CHANCEL

48. SIGNATURE OF ALTAR

49. SIGNATURE OF PULPIT

50. SIGNATURE OF TABERNACLE

51. SIGNATURE OF CHANCEL

52. SIGNATURE OF TRANCHE

53. SIGNATURE OF AISLE

54. SIGNATURE OF NAVE

55. SIGNATURE OF QUORE

56. SIGNATURE OF CHANCEL

57. SIGNATURE OF ALTAR

58. SIGNATURE OF PULPIT

59. SIGNATURE OF TABERNACLE

60. SIGNATURE OF CHANCEL

61. SIGNATURE OF TRANCHE

62. SIGNATURE OF AISLE

63. SIGNATURE OF NAVE

64. SIGNATURE OF QUORE

65. SIGNATURE OF CHANCEL

66. SIGNATURE OF ALTAR

67. SIGNATURE OF PULPIT

68. SIGNATURE OF TABERNACLE

69. SIGNATURE OF CHANCEL

70. SIGNATURE OF TRANCHE

71. SIGNATURE OF AISLE

72. SIGNATURE OF NAVE

73. SIGNATURE OF QUORE

74. SIGNATURE OF CHANCEL

75. SIGNATURE OF ALTAR

76. SIGNATURE OF PULPIT

77. SIGNATURE OF TABERNACLE

78. SIGNATURE OF CHANCEL

79. SIGNATURE OF TRANCHE

80. SIGNATURE OF AISLE

81. SIGNATURE OF NAVE

82. SIGNATURE OF QUORE

83. SIGNATURE OF CHANCEL

84. SIGNATURE OF ALTAR

85. SIGNATURE OF PULPIT

86. SIGNATURE OF TABERNACLE

87. SIGNATURE OF CHANCEL

88. SIGNATURE OF TRANCHE

89. SIGNATURE OF AISLE

90. SIGNATURE OF NAVE

91. SIGNATURE OF QUORE

92. SIGNATURE OF CHANCEL

93. SIGNATURE OF ALTAR

94. SIGNATURE OF PULPIT

95. SIGNATURE OF TABERNACLE

96. SIGNATURE OF CHANCEL

97. SIGNATURE OF TRANCHE

98. SIGNATURE OF AISLE

99. SIGNATURE OF NAVE

100. SIGNATURE OF QUORE

101. SIGNATURE OF CHANCEL

102. SIGNATURE OF ALTAR

103. SIGNATURE OF PULPIT

104. SIGNATURE OF TABERNACLE

105. SIGNATURE OF CHANCEL

106. SIGNATURE OF TRANCHE

107. SIGNATURE OF AISLE

108. SIGNATURE OF NAVE

109. SIGNATURE OF QUORE

110. SIGNATURE OF CHANCEL

111. SIGNATURE OF ALTAR

112. SIGNATURE OF PULPIT

113. SIGNATURE OF TABERNACLE

114. SIGNATURE OF CHANCEL

115. SIGNATURE OF TRANCHE

116. SIGNATURE OF AISLE

117. SIGNATURE OF NAVE

118. SIGNATURE OF QUORE

119. SIGNATURE OF CHANCEL

120. SIGNATURE OF ALTAR

121. SIGNATURE OF PULPIT

122. SIGNATURE OF TABERNACLE

123. SIGNATURE OF CHANCEL

124. SIGNATURE OF TRANCHE

125. SIGNATURE OF AISLE

126. SIGNATURE OF NAVE

127. SIGNATURE OF QUORE

128. SIGNATURE OF CHANCEL

BUREAU V. S.

MAR 20 1900

RECEIVED

2869

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
c. LENGTH OF STAY IN 1b <b>9 Months</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6 East Ninth Street</b>				d. STREET ADDRESS <b>6 East Ninth Street</b>			
3. NAME OF DECEASED (Type or print) First <b>GRACE</b> Middle <b>MYERS</b> Last <b>GILBERT</b>				4. DATE OF DEATH Month <b>March</b> Day <b>18</b> Year <b>1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 18, 1895</b>		9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery Store</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Myers</b>				14. MOTHER'S MAIDEN NAME <b>Gertrude Rotz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>202-20-1610</b>		17. INFORMANT <b>Mrs. Paul K. Huber, Frederick, Maryland</b> Address <b>6 East Ninth Street</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b> <b>year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma, right breast.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 29, 1955</b> , to <b>March 18, 1956</b> , that I last saw the deceased alive on <b>March 17, 1956</b> , and that death occurred at <b>12:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>East Church Street, Frederick, Maryland</b> DATE SIGNED _____							
ACTUAL SIGNATURE <b>Robert S. Turner, Jr.</b> M.D.				PHYSICIAN'S NAME (Type) <b>Dr. Robert S. Turner</b> <b>East Church Street, Frederick, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 20, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Northland Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Franklin County, Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b> ADDRESS _____				24a. REC'D BY REGISTRAR <b>DATE 19 March 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth V. Hack</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1000

**BUREAU V. S.**

MAR 21 1956

RECEIVED



## CERTIFICATE OF DEATH

Reg. Dist. No. 131

2893

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Myersville</b>		c. LENGTH OF STAY IN 1b <b>50 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Myersville</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>no</b>				d. STREET ADDRESS <b>no</b>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Elizabeth</b> Last <b>Gladhill</b>				4. DATE OF DEATH Month <b>3</b> Day <b>21</b> Year <b>1956</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/25/1880</b>		9. AGE (In years last birthday) yrs. <b>75</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Carlton Palmer</b>				14. MOTHER'S MAIDEN NAME <b>Ellen Poffenberger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Melvin O. Gladhill, Myersville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>17 mo</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct</b> , 1954, to <b>Jan 20</b> , 1956, that I last saw the deceased alive on <b>Jan 20</b> , 1956, and that death occurred at <b>11:00 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Elmer Harp</b> M.D.				ADDRESS (Street, city, or town, state) DATE SIGNED <b>Middletown 3-23-56</b>			
PHYSICIAN'S NAME (Type) <b>Dr. J. Elmer Harp</b>				<b>Middletown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>3/24/1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Community Cem., Harmony Frederick Co., Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Co.,</b>				ADDRESS <b>Middletown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>26 March '56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Elizabeth B. Herb</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

## 181

BUREAU V. S.

MAR 27 1956

RECEIVED

2870

## CERTIFICATE OF DEATH

Reg. Dist. No.

02859  
131

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>11 FREDERICK</b>				c. LENGTH OF STAY IN 1b <b>4 WEEKS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>MAURICE LEE GRINDER</b>				4. DATE OF DEATH Month Day Year <b>MARCH 31 1956</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 3 - 1892</b>	9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DRILLER - QUARRY</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>CEMENT PLANT</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>THOMAS GRINDER</b>				14. MOTHER'S MAIDEN NAME <b>ANNIE OTTO</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>215-67-0415</b>			
17. INFORMANT <b>LULA H GRINDER</b> Address <b>UNION BRIDGE MD</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Stomach</b> <b>196x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Jan 15, 1956</b> to <b>Mar 30, 1956</b> , that I last saw the deceased alive on <b>Mar 30, 1956</b> , and that death occurred at <b>2:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Union Bridge MD</b> DATE SIGNED <b>Mar 31</b> ACTUAL SIGNATURE <b>J. H. Messler</b> M.D. PHYSICIAN'S NAME (Type) <b>J. H. Messler</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/2/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>PIPE CREEK CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>CARROLL COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>D. HARTZLER &amp; SONS</b> ADDRESS <b>UNION BRIDGE MD.</b>				24a. REC'D BY REGISTRAR <b>DATE 30 April 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth S. Heck</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 11

151

**BUREAU V. S.**

APR 4 1956

RECEIVED

2871

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

02860

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>10 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>69 Memorial Hospital</b>				d. STREET ADDRESS <b>Uniontown</b>			
3. NAME OF DECEASED (Type or print) First <b>Willie</b> Middle <b>Herman</b> Last <b>Haines</b>				4. DATE OF DEATH Month <b>March</b> Day <b>29</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 21, 1874</b>		9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Nathan Haines</b>				14. MOTHER'S MAIDEN NAME <b>Fannie Stultz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. Edward Dingle, Uniontown, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocarditis - gangrenous leg</b> 450.1 DUE TO (b) <b>Arterio Sclerosis -</b> DUE TO (c) <b>Gangrenous leg amputated</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>Jan 15 - to March 29</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Jan 15, 1956</b> , to <b>March 29, 1956</b> , that I last saw the deceased alive on <b>March 29, 1956</b> , and that death occurred at <b>2 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>E P Thomas</b>				ADDRESS (Street, city or town, state) <b>Frederick, Md</b>			
PHYSICIAN'S NAME (Type) <b>E P Thomas</b>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 2, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Church of God Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Uniontown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mary C. Fess</b>				ADDRESS <b>Taneytown, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE 31 March 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Elizabeth B. Heck</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Illegible]</p>		<p>2. SEX [Illegible]</p>		<p>3. AGE [Illegible]</p>	
<p>4. DATE OF DEATH [Illegible]</p>		<p>5. TIME OF DEATH [Illegible]</p>		<p>6. PLACE OF DEATH [Illegible]</p>	
<p>7. CAUSE OF DEATH [Illegible]</p>		<p>8. MANNER OF DEATH [Illegible]</p>		<p>9. PLACE OF BIRTH [Illegible]</p>	
<p>10. OCCUPATION [Illegible]</p>		<p>11. MARITAL STATUS [Illegible]</p>		<p>12. COLOR [Illegible]</p>	
<p>13. EDUCATION [Illegible]</p>		<p>14. RELIGION [Illegible]</p>		<p>15. PREVIOUS ILLNESS [Illegible]</p>	
<p>16. SIGNATURE OF DECEASED [Illegible]</p>		<p>17. SIGNATURE OF WITNESS [Illegible]</p>		<p>18. SIGNATURE OF PHYSICIAN [Illegible]</p>	
<p>19. SIGNATURE OF CORONER [Illegible]</p>		<p>20. SIGNATURE OF JURY [Illegible]</p>		<p>21. SIGNATURE OF JUDGE [Illegible]</p>	
<p>22. SIGNATURE OF CLERK [Illegible]</p>		<p>23. SIGNATURE OF REGISTRAR [Illegible]</p>		<p>24. SIGNATURE OF ASSISTANT REGISTRAR [Illegible]</p>	

BUREAU A. 2

APR 2 1956

RECEIVED



1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Sabillasville</b>				c. LENGTH OF STAY IN 1b <b>30 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Omah</b> Middle <b>S.</b> Last <b>Hayman</b>				4. DATE OF DEATH Month <b>March</b> Day <b>3</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 17. 1900</b>		9. AGE (In years last birthday) <b>56</b> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Brakeman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Penna. R.R.</b>		11. BIRTHPLACE (State or foreign country) <b>Delmar Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Wilmer Hayman</b>				14. MOTHER'S MAIDEN NAME <b>Katie Derrickson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>714-18-0383</b>		17. INFORMANT <b>Virgie Hayman</b> Address <b>Sabillasville. MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY TUBERCULOSIS, B. LATERAL</b> <b>002X</b> DUE TO <b>FAR ADVANCED, ACTIVE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4 Oct 1951</b> to <b>3 March 1956</b> , that I last saw the deceased alive on <b>2 March 1956</b> , and that death occurred at <b>6:00 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Blue Ridge Summit Pa</b> DATE SIGNED <b>3 March 1956</b> ACTUAL SIGNATURE <b>Harry H. Youngs, Jr.</b> M.D. PHYSICIAN'S NAME (Type) <b>Harry H. Youngs, Jr., M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mch. 6th. 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Thurmont Fredk. Co. Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Greager</b> ADDRESS <b>Thurmont</b>				24a. REC'D BY REGISTRAR <b>5</b> DATE <b>1956</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. L. B. Layton</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completed, filled in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		45		JAN 15 1905		BALTIMORE		MD		MD		USA	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
LABORER		HEART DISEASE		NATURAL		JAN 15 1955		BALTIMORE		MD		MD		USA	
EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED		OTHER	
HIGH SCHOOL		METHODIST		YES		NO		YES		NO		YES		NO	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH	
JAMES H. HARRIS		MARY J. HARRIS		LABORER		HOUSEWIFE		BALTIMORE		BALTIMORE		JAN 15 1905		JAN 15 1905	
FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH	
FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH	
LABORER		HOUSEWIFE		BALTIMORE		BALTIMORE		JAN 15 1905		JAN 15 1905		JAN 15 1955		JAN 15 1955	
FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH	
FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH	
FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH	
BALTIMORE		BALTIMORE		JAN 15 1955		JAN 15 1955		HEART DISEASE		HEART DISEASE		NATURAL		NATURAL	
FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH	
FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH	
FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH	
BALTIMORE		BALTIMORE		JAN 15 1955		JAN 15 1955		HEART DISEASE		HEART DISEASE		NATURAL		NATURAL	

BUREAU V. S.

MAR 5 1956

RECEIVED

1  
INSTRUCTIONS  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.  
VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02862

2884

# CERTIFICATE OF DEATH

Reg. Dist. No. 141

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Brunswick		10 yrs.		TOWN Brunswick			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 521 West B. Street				STREET ADDRESS (If rural give location) 521 West B. Street			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) ARTIE FRANCES HENRY				4. DATE OF DEATH (Month) (Day) (Year) March 22, 1956			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Nov. 6, 1860	9. AGE last birthday 95 yrs.	IF UNDER 1 YEAR Months 4 Days 16		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Tom's Brook, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Scott				14. MOTHER'S MAIDEN NAME Lydia Hahn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Mrs. Lillian Cage 521 W. B Street, Brunswick, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
421.4 IMMEDIATE CAUSE (A)				LABORER Heart Disease			
ANTECEDENT CAUSE(S) DUE TO				Hypertension			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH 7 yrs			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5/1/36, to 3/22, 1956, that I last saw the deceased alive on 3/26, 1956, and that death occurred at 11:30 P.M. from the causes and on the date stated above.							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED 3/24/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		DATE THEREOF 3/23/56		NAME OF CEMETERY OR CREMATORY Mt. Hebron Cemetery		LOCATION (City, town, or county) Winchester, Virginia	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Harpers Ferry, West Virginia	
DATE 3-24-56							

# CERTIFICATE OF DEATH

8882

DEPARTMENT OF HEALTH - BALTIMORE, MD.

Reg. Dist. No.

LOCAL HEALTH OFFICE (If not a resident)

DATE OF DEATH

MARRIAGE

DATE OF BIRTH

SEX

RACE

EDUCATION

RELIGION

PROFESSION

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

BUREAU V. S.

MAR 27 1956

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02863

2872

## CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>4 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>				d. STREET ADDRESS <u>Reich's Ford Road</u>			
3. NAME OF DECEASED (Type or print) First <u>BEATRICE</u> Middle <u>NAOMI</u> Last <u>HOGAN</u>				4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>May 27, 1898</u>		9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elmer E. Hildebrand</u>				14. MOTHER'S MAIDEN NAME <u>Daisy Miss</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. George J. Hogan, Frederick, R.F.D.#6, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Circumscised left kidney</u> <u>180X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Renemia</u> DUE TO (c) <u>Secondary anemia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 mo. +</u> <u>10 days</u> <u>6 mo. +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>May 10, 1955</u> to <u>March 2, 1956</u> , that I last saw the deceased alive on <u>March 2, 1956</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B. O. Thomas</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>North Market Street, Frederick, Md. 3/5/56</u>			
PHYSICIAN'S NAME (Type) <u>Dr. B. O. Thomas Sr.</u>				North Market Street, Frederick, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 5, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rocky Springs Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>5 March 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth S. Heck</u>	





1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02864

2873 **CERTIFICATE OF DEATH**

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Frederick</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frederick</u>		LENGTH OF STAY (In this place) <u>12 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Brunswick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial</u>				STREET ADDRESS (If rural give location) <u>4 East Potomac</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Arlington G. Horine</u>				<b>4. DATE OF DEATH</b> (Month) <u>3</u> (Day) <u>15</u> (Year) <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug. 1st. 1862</u>	9. AGE last birthday <u>93</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Physician</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Alpheus Horine</u>				14. MOTHER'S MAIDEN NAME <u>Frances Grove</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>XXXXXXXXXX</u>		17. INFORMANT & ADDRESS <u>A.L.W. Horine, Brunswick, Maryland</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
450.1 IMMEDIATE CAUSE (A) <u>Gangrene, left lower extremity</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis, generalized</u>						<u>10-15 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Bronchopneumonia</u>						<u>2 WKS.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/3</u> , 19 <u>56</u> , to <u>3/15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/15</u> , 19 <u>56</u> , and that death occurred at <u>9:40 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Henry V. Chase</u>				ADDRESS (Street, city, town, state) <u>M.D. 4 E. Church St. Frederick Md</u>		DATE SIGNED <u>3/15/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-17-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Union</u>		LOCATION (City, town, or county) (State) <u>Burkittsville, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>MAR 20 1956</u>		REGISTRAR'S SIGNATURE <u>Mr. Elj. G. Hecks</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>3 Lee Fute</u>		ADDRESS <u>Brunswick, Maryland</u>	

113804

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE, MD

# CERTIFICATE OF DEATH

For Filing

1. DEATH OF DECEASED

2. PLACE OF DEATH

3. CAUSE OF DEATH

4. DATE OF DEATH

5. TIME OF DEATH

6. PLACE OF BIRTH

7. SEX

8. AGE

9. OCCUPATION

10. MARITAL STATUS

11. EDUCATION

12. RELIGION

BUREAU V. S.

MAR 20 1956

RECEIVED

13. SIGNATURE OF DECEASED

14. SIGNATURE OF WITNESS

15. SIGNATURE OF PHYSICIAN

16. SIGNATURE OF CLERK

17. SIGNATURE OF REGISTRAR

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE, MD  
This certificate is to be filed in the office of the Registrar of Vital Statistics, Baltimore, Maryland, and a copy of the same is to be furnished to the local health officer of the city or town in which the death occurred.  
The local health officer is to be notified of the death of the deceased by the physician or other person who has knowledge of the death, and is to file a copy of this certificate in the office of the Registrar of Vital Statistics, Baltimore, Maryland, and a copy of the same is to be furnished to the local health officer of the city or town in which the death occurred.  
The local health officer is to be notified of the death of the deceased by the physician or other person who has knowledge of the death, and is to file a copy of this certificate in the office of the Registrar of Vital Statistics, Baltimore, Maryland, and a copy of the same is to be furnished to the local health officer of the city or town in which the death occurred.

2895

CERTIFICATE OF DEATH

02865

Reg. Dist. No.

144

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Thurmont</b>		c. LENGTH OF STAY IN 1b <b>50 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>50</b>		d. STREET ADDRESS <b>Rural Thurmont</b>	
3. NAME OF DECEASED (Type or print) First <b>Carlton</b> Middle <b>Vincent</b> Last <b>Jackson</b>		4. DATE OF DEATH Month <b>March</b> Day <b>10</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 1, 1872</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick Co. Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Thomas Jackson</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth McDonald</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Morris Jackson</b>		Address <b>Thurmont R.F.D MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension</b> DUE TO (c) <b>Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>28 hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar. 9, 1956</b> , to <b>Mar. 10, 1956</b> , that I last saw the deceased alive on <b>Mar. 10, 1956</b> , and that death occurred at <b>3:45 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Franklin M. Birely</b> M.D.		ADDRESS (Street, city or town, state) <b>Thurmont Md.</b> DATE SIGNED <b>3/12/56</b>	
PHYSICIAN'S NAME (Type) <b>Thurmont MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 13, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Utica Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Utica, Frederick Co MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Greager</b>		24a. REC'D BY REGISTRAR <b>Blanche Eyles</b>	
ADDRESS <b>Thurmont MD</b>		DATE <b>MAR 14 1956</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrator prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2874

## CERTIFICATE OF DEATH

02866

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 11 Frederick		c. LENGTH OF STAY IN 1b Since-1927		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 69 Frederick Memorial Hospital				d. STREET ADDRESS 217 East Second Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MIEGIA Middle VIRGINIA Last KRANTZ				4. DATE OF DEATH Month March 30, Day 19, Year 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 Jan 1871	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Simeon L. Bast				14. MOTHER'S MAIDEN NAME Ann J. Cutsail			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address John H. Krantz, R. F. D. #4, Frederick, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocarditis DUE TO (c) Appendicitis at cross Subdiaphragmatic cross 260X Diabetes mellitus							INTERVAL BETWEEN ONSET AND DEATH 10 min. 3 y 10. 11 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Mar 19, 1956, to Mar 30, 1956, that I last saw the deceased alive on Mar 30, 1956, and that death occurred at 8:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 7 N. Market St., Frederick, Md. 3/31/56 ACTUAL SIGNATURE H. F. Kline M.D. 7 N. Market St., Frederick, Md. 3/31/56 PHYSICIAN'S NAME (Type) H. F. Kline 7 N. Market St., Frederick, Md. 3/31/56							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3 Apr 1956		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS		24a. REC'D BY REGISTRAR DATE 31 March 56	
				24b. REGISTRAR'S SIGNATURE Elizabeth S. Heck			

BUREAU V. S.

1956 2 14

RECEIVED

2896

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b>		c. LENGTH OF STAY IN 1b <b>25 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MD</b>		d. STREET ADDRESS <b>Thurmont</b>	
3. NAME OF DECEASED (Type or print) <b>Fannie</b> First <b>May</b> Middle <b>Martin</b> Last		4. DATE OF DEATH <b>March</b> Month <b>8</b> Day <b>19</b> Year <b>56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 12. 1875</b>
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Thurmont MD</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>			
13. FATHER'S NAME <b>Cyrus Favorite</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Hesson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT Address <b>Esther Weddle Thurmont, Md</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart disease Congestive type</b> <b>434.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>0</b>			INTERVAL BETWEEN ONSET AND DEATH <b>14 mos.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec. 20</b> , 19 <b>54</b> to <b>Mar. 8</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Mar. 7</b> , 19 <b>56</b> , and that death occurred at <b>12:35 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Thurmont, Md.</b> DATE SIGNED			
ACTUAL SIGNATURE <b>James K. Gray</b>		M.D. <b>Thurmont, Md.</b>	
PHYSICIAN'S NAME (Type) <b>James K. Gray</b>		<b>Thurmont Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mch. 11. 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>United Brethern Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Thurmont Fredk. Co. MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b>		ADDRESS <b>Thurmont, MD</b>	
24a. REC'D BY REGISTRAR <b>MAR 12 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Blanche Cyler</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 12 1956

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 19

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Life</b>		d. STREET ADDRESS <b>West Main St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Linnie</b> Middle <b>May</b> Last <b>McGuigan</b>		4. DATE OF DEATH Month <b>March</b> Day <b>29</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 3, 1877</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired School teacher-Public School</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Thurmont, Md.</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>James A. McGuigan</b>	
14. MOTHER'S MAIDEN NAME <b>Miranda Arthur</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Miss Addie Baltzell-Thurmont, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension</b> (c) <b>Arteriosclerotic cardio-vascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days (49)</b> <b>1 mo.</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of ascending colon</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar. 26, 1956</b> , to <b>Mar. 29, 1956</b> , that I last saw the deceased alive on <b>Mar. 29, 1956</b> , and that death occurred at <b>6:00 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>M. Franklin Birely</b> M.D.		ADDRESS (Street, city or town, state) <b>Thurmont, Md.</b> DATE SIGNED <b>3/30/56</b>	
PHYSICIAN'S NAME (Type) <b>M. Franklin Birely</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>April 1, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>U.B. Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Thurmont, Md. Frederick Co.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. O'Quinn</b>		24a. REC'D BY REGISTRAR <b>April 2, 1956</b> 24b. REGISTRAR'S SIGNATURE <b>Blanche Eyles</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Frederick

Maryland

Residence

Frederick

Thurmont, Md.

Age

Thurmont

West Main St.

McGowan

Ray

Ann

Sept. 1, 1877

White

Female

Thurmont, Md.

Retired School Teacher - Public School

Married

James A. McGowan

No

Name

Miss Addie McGowan - Thurmont, Md.

Certified by

Dr. J. H. McGowan

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Burial Officer

Signature of Minister

Signature of Undertaker

Signature of Cemetery

Signature of Other

Signature of Other

BUREAU V. S.

APR 2 1956

RECEIVED

W. Franklin Birney

Burial April 1, 1956 - U.S. Cemetery

## MARYLAND STATE DEPARTMENT OF HEALTH

02870

2875

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH. COUNTY <u>Fred</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <u>MD</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fred</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - New Windsor</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Fred Mem Hosp.</u>		STREET ADDRESS (If rural, give location) <u>06 x - 2</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Emma</u> (Middle) <u>L.</u> (Last) <u>Pickett</u>		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>9</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>9-18-1895</u>
9. AGE last birthday <u>60</u> yrs.		10. If under 1 year Months <u>  </u> Days <u>  </u> If under 24 hrs. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Williams</u>		14. MOTHER'S MAIDEN NAME <u>May Shane</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Howard Pickett, New Windsor, MD</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Carcinoma of the head of the pancreas

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 2/22/1956, to 3/9/1956, that I last saw the deceasedalive on 3/9/1956, and that death occurred at 2:30 P.M. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3-12-1956</u>	NAME OF CEMETERY OR CREMATORY <u>Taylorville</u>	LOCATION (City, town, or county) <u>Carroll Co.</u>	(State) <u>MD</u>
DATE REC'D BY LOCAL REG. <u>9 March 1956</u>	REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>	24. FUNERAL DIRECTOR <u>S.M. Waltz, Winfield</u>		ADDRESS <u>MD</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 12 1956

BUREAU V. S.

2898  
CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>xFrederick-Rural RD#5</b>				c. LENGTH OF STAY IN 1b <b>Frederick</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick County Chronic Hospital</b>				d. STREET ADDRESS <b>18 West College Terrace</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ROY</b> Middle <b>SYLVESTER</b> Last <b>PICKETT</b>				4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>19 Mar 1892</b>	9. AGE (In years last birthday) yrs. <b>64</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas W. Pickett</b>				14. MOTHER'S MAIDEN NAME <b>Rosa Florence Brashears</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-3395</b>		17. INFORMANT Address <b>Mrs. J. Wilson Stup, 18 West College Terrace, Frederick, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio Sclerosis</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>34 hrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>March 29, 1956</b> , to <b>March 31, 1956</b> , that I last saw the deceased alive on <b>March 29, 1956</b> , and that death occurred at <b>6:30 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>B. O. Thomas</b>				M.D. <b>North Market Street, Frederick, Md. 3/31/56</b>			
PHYSICIAN'S NAME (Type) <b>Dr. B. O. Thomas Sr.</b>				<b>North Market Street, Frederick, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3 Apr 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison and Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>DATE 31 March '56</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Hecla</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete certificate filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1958. 28.

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2899

## CERTIFICATE OF DEATH

Reg. Dist. 02872

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Emmitsburg</b>		c. LENGTH OF STAY IN 1b <b>50 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Clarence Alvin Putman</b>		4. DATE OF DEATH Month Day Year <b>March 28. 19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 21. 1879</b>
9. AGE (In years last birthday) yrs. <b>76</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John H. Putman</b>		14. MOTHER'S MAIDEN NAME <b>Phoebe A. Harp</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-24-3739</b>	
17. INFORMANT <b>Mrs. Sadie M. Putman</b>		Address <b>Taneytown, R.D. 2, MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> <b>260X</b> DUE TO (b) <b>Diabetes Mel.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>6 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-1-</b> , 19 <b>54</b> , to <b>3-27</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>3/26</b> , 19 <b>56</b> , and that death occurred at <b>9 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>T. H. Legg</b> M.D. <b>Union Bridge MD 3-27-56</b>			
ACTUAL SIGNATURE			
PHYSICIAN'S NAME (Type) <b>T. H. Legg</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar. 31. 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Church of Brethern. Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Rocky Ridge. Fredk Co. MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Greager</b>		ADDRESS <b>Thurmont MD</b>	24a. REC'D BY REGISTRAR <b>April 2, 1956</b>
		24b. REGISTRAR'S SIGNATURE <b>A. H. Hedrick</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2000

## CERTIFICATE OF DEATH

02873

Reg. Dist. No. 131

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Frederick</u>		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Braddock Heights</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Braddock Heights Fred. Co., Md.</u>		STREET ADDRESS (If rural give location) <u>Braddock Heights Fred. Co., Md.</u>					
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Pauline</u> <u>Evitral</u> <u>Reid</u>				<b>4. DATE OF DEATH</b> (Month) <u>March</u> (Day) <u>9</u> (Year) <u>1956</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>Colored</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED</b> (Specify) <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>March 11, 1871</u>	<b>9. AGE last birthday</b> <u>84</u> yrs.	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HRS.</b> Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> *****		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Frederick, Co. Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <u>Edward Holland</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Eliza Ann Snowden</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Carter Reid Braddock, Heights Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>170X IMMEDIATE CAUSE (A)</b> <u>Generalized Carcinomatosis</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>3 1/2 yrs.</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Carcinoma of Right Breast</u>						<u>5 years</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>March 8, 1954</u>, to <u>March 9, 1956</u>, that I last saw the deceased alive on <u>3/9</u>, 19<u>56</u>, and that death occurred at <u>10:45</u> AM, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>J. D. Scherbaum</u>				<b>DATE SIGNED</b> <u>22 1/2 March 8 1956</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Mar. 12, 1956</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Faievew</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Frederick, Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Elizabeth S. Herb</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Charles E. Nicks III</u>			
<b>DATE</b> <u>12 March 1956</u>				<b>ADDRESS</b> <u>Fred. Md.</u>			

THE UNIVERSITY OF CHICAGO

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**2876 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

02874  
 Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>Lifelong</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Lifelong</u>				d. STREET ADDRESS <u>2455 Market</u>			
3. NAME OF DECEASED (Type or print) <u>Myrtle</u> First <u>Rowe</u> Middle Last				4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 1994</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hosiery</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Paulis Rowe</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ellen Bennett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-10-1248</u>		17. INFORMANT <u>William S. Bennett, Frederick, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation by hanging</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <u>  </u> 974x						INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>B. O. Thomas</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>B. O. Thomas</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 21, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Crane</u> <u>RWS</u>				ADDRESS <u>Frederick Md</u>		24a. REC'D BY REGISTRAR DATE <u>21 March 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Elizabeth Y. Heck</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
 MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
RACE [Faint text]		OCCUPATION [Faint text]		PLACE OF BIRTH [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		SIGNATURE OF EXAMINER [Faint text]	
SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF WITNESS [Faint text]	

BUREAU V. S.

RECEIVED  
 MAR 22 1956

2877

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02875

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Fredrick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Fredrick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fredrick</u>				c. LENGTH OF STAY IN 1b <u>5 da</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Thurmont - RURAL</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fredrick Memorial Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Shirley</u> Middle <u>M.V.</u> Last <u>Shaffer</u>				4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May .29.1939</u>	
9. AGE (In years last birthday) <u>16</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Thurmont Fredk Co MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Paul W. Shaffer</u>				14. MOTHER'S MAIDEN NAME <u>Hazel Duncan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Paul W. Shaffer Thurmont MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Abscess</u> <u>340.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Basal Meningitis</u> (c) <u>Lung Abscess</u> DUE TO cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>		Month, Day, Year <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>B.O. Thomas</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>B.O. Thomas</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <u>March 17-56</u>							
22a. BURIAL, CREMATION, REINTERMENT <u>Burial</u>		22b. DATE THEREOF <u>Mch. 20. 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Blue Ridge Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Thurmont Fredk. Co MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Greager</u>				ADDRESS <u>Thurmont. MD</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 20 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mrs. Elly G. Zick</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAR 20 1956

2878

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY in 1b <b>5 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>ALBERT</b> Last <b>SIER</b>				4. DATE OF DEATH Month <b>March 27,</b> Day <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>21 Nov 1872</b>	
9. AGE (In years last birthday) yrs. <b>83</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Trackman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad Company</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Joseph B. Sier</b>			
14. MOTHER'S MAIDEN NAME <b>Sarah Louise Ford</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>705-10-2059</b>				17. INFORMANT <b>Miss Cora I. Sier, R. F. D. #6, Frederick, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>10 yrs +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <b>3/22, 1956</b> , to <b>3/27, 1956</b> , that I last saw the deceased alive on <b>3/26, 1956</b> , and that death occurred at <b>3:30A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4 E. Church St., Frederick, Md.</b> DATE SIGNED <b>3/27/56</b> ACTUAL SIGNATURE <b>Henry V. Chase</b> M.D. PHYSICIAN'S NAME (Type) <b>Henry V. Chase</b> <b>4 E. Church St., Frederick, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>29 Mar 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>28 March 56</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 5 1928		MEMPHIS		TENNESSEE		UNITED STATES		UNITED STATES	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HEIGHT		WEIGHT	
ATTORNEY		HIGH SCHOOL		MARRIED		METHODIST		WHITE		WHITE		5' 10"		175	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		POST-MORTEM	
APR 4 1968		MEMPHIS		HEART DISEASE		SUICIDE		CORONARY ARTERY DISEASE		PAIN IN CHEST		NO		NO	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE		PLACE		CAUSE		MANNER		DISEASE		SYMPTOMS		TREATMENT		POST-MORTEM	
APR 4 1968		MEMPHIS		HEART DISEASE		SUICIDE		CORONARY ARTERY DISEASE		PAIN IN CHEST		NO		NO	

BUREAU V. S.

MAR 29 1956

RECEIVED



2901

## CERTIFICATE OF DEATH

Reg. Dist. No.

144

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>Glendera</b> Middle <b>Viola</b> Last <b>Stocksdale</b>		4. DATE OF DEATH Month <b>March</b> Day <b>17</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 2 1877</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Thurmont Fredk Co Md</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>George W. Stocksdale</b>	
14. MOTHER'S MAIDEN NAME <b>Mary C. Bachtell</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT Address <b>Mrs W.Z. Willhide Thurmont MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart disease Coronary occlusion</b> <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Sclerosis</b> (c) <b>Coronary Sclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>Sudden</b> <b>1 yr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan. 15</b> , 19 <b>55</b> to <b>Mar. 17</b> , 19 <b>56</b> , that I lost saw the deceased alive on <b>Mar 1 - 1956</b> , and that death occurred at <b>5 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James K. Gray</b>		ADDRESS (Street, city or town, state) <b>Thurmont Md</b> DATE SIGNED <b>Mar. 17-56</b>	
PHYSICIAN'S NAME (Type) <b>James K. Gray</b>		<b>Thurmont. MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar. 20, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>United Brethern Cem</b>	22d. LOCATION (City, town, or county) (State) <b>Thurmont Fredk. Co MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Greager</b>		24. REC'D BY REGISTRAR <b>MAR 20 1956</b>	
ADDRESS <b>Thurmont. MD</b>		24b. REGISTRAR'S SIGNATURE <b>Blanche Cyler</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2885 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02878

Reg. Dist. No. 141

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Frederick</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>35 Brunswick</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>00 II9 5th. Avenue</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>35 Brunswick</u> d. STREET ADDRESS <u>II9 5th. Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Lula La Rue Talbott</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>March 4 1956</u>											
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>II-4-1900</u>		<b>9. AGE</b> (In years last birthday) <u>55</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Cashier</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>B &amp; O Y.M.C.A.</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Henry Talbott</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Minnie Holtman</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> Address <u>Marion Talbott, Brunswick, Maryland</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____												INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
<b>ACTUAL SIGNATURE</b> <u>B.D. Thomas</u>						<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b>					
<b>EXAMINER'S NAME (Type)</b> <u>B.O. Thomas</u>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<u>March 5, 1956</u>					
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>															
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>3-8-1956</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Park Heights</u>				<b>22d. LOCATION</b> (City, town, or county) (State) <u>Brunswick, Maryland</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>B. Lee Feste</u>						<b>ADDRESS</b> <u>Brunswick, Maryland</u>				<b>24a. REC'D BY REGISTRAR</b> <u>DATE 3-7-56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Kathryn H. Brown</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES J. HENRY		45		M		W		MAY 10, 1934	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
100 N. BOSTON ST.		LABORER		HEART DISEASE		NATURAL		HOME	
CITY		COUNTY		TOWN		STATE		COUNTRY	
BOSTON		SUFFOLK		DORCHESTER		MASS.		U.S.A.	
DATE OF BIRTH		DATE OF DEATH		HOURS		MINUTES		SECOND	
MAY 10, 1934		MAY 10, 1934		10		00		00	
TIME OF DAY		TEMPERATURE		PULSE		RESPIRATION		BLOOD PRESSURE	
10:00 AM		98.6		100		20		120/80	
PLACE OF DEATH		MANNER OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
HOME		NATURAL		HEART DISEASE		NATURAL		HOME	
CITY		COUNTY		TOWN		STATE		COUNTRY	
BOSTON		SUFFOLK		DORCHESTER		MASS.		U.S.A.	

RECEIVED  
 MAR 13 1934  
 BUREAU V. E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, Film 796-1-23-56  
2879

CERTIFICATE OF DEATH

02879

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN TB <b>18 years</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				d. STREET ADDRESS <b>356 East Third Street</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>356 East Third Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JESSE</b> Middle <b>ELSWORTH</b> Last <b>WETZEL</b>				4. DATE OF DEATH Month <b>March</b> Day <b>21</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 26, 1904</b>	
9. AGE (In years last birthday) yrs. <b>52</b>		IF UNDER 1 YEAR Months <b>52</b> Days <b>52</b> Hours <b>52</b> Min. <b>52</b>		IF UNDER 24 HRS. Months <b>52</b> Days <b>52</b> Hours <b>52</b> Min. <b>52</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Chemical Corps</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Marshall L. Wetzel</b>				14. MOTHER'S MAIDEN NAME <b>Annabelle Ecker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>217-10-9095</b>			
17. INFORMANT <b>Mrs. Jesse E. Wetzel - 356 E. Third Street</b>				Address <b>Frederick, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of lung with cerebral metastases</b> <b>163X</b> DUE TO (b) <b>18 mo</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Sept. 1955</b> , to <b>March 21, 1956</b> , that I last saw the deceased alive on <b>March 20, 1956</b> , and that death occurred at <b>7:15 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>35 E Church Frederick Md</b> DATE SIGNED <b>3-23-56</b> ACTUAL SIGNATURE <b>Rex R Martin</b> M.D. PHYSICIAN'S NAME (Type) <b>Rex R MARTIN MD.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>March 23, 1956</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Hope Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Woodsboro Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Clinch &amp; Son - Frederick - Md.</b>				24a. REC'D BY REGISTRAR <b>DATE 23 March 1956</b>			
24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Hech</b>							



## 131

BUREAU V. S.

MAR 27 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2902

## CERTIFICATE OF DEATH

02880 144

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Thurmont</b>				c. LENGTH OF STAY IN 1b <b>21 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Thurmont</b>			
				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>Grace</b> Middle <b>Burke</b> Last <b>Williams</b>				4. DATE OF DEATH Month <b>March</b> Day <b>14</b> Year <b>1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 11. 1890</b>		9. AGE (In years lost day) <b>65</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Petersburg Va</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Joseph Burke</b>				14. MOTHER'S MAIDEN NAME <b>Mariah Harrington</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Garland B. Williams Sr. Thurmont. MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Disease Chr. Valvular</b> <b>421.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Sept. 15</b> 19 <b>55</b> , to <b>Mar 14</b> 19 <b>56</b> , that I last saw the deceased alive on <b>Mar. 5</b> 19 <b>56</b> , and that death occurred at <b>12:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Thurmont - Md.</b> DATE SIGNED <b>3/15/56</b>							
ACTUAL SIGNATURE <b>James H. Gray</b>				M.D. <b>Thurmont Md</b>			
PHYSICIAN'S NAME (Type) <b>James H. Gray</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mch. 17. 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt Carmel Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Thurmont Fredk Co Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Greager</b>				ADDRESS <b>Thurmont MD</b>		24a. REC'D BY REGISTRAR <b>Mar 19 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mr. H. Z. Z...</b>		24c. REGISTRAR'S SIGNATURE <b>Mr. H. Z. Z...</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]		PLACE OF BIRTH [Illegible]	
OCCUPATION [Illegible]		MARITAL STATUS [Illegible]		EDUCATION [Illegible]	
PREVIOUS ILLNESS [Illegible]		MEDICAL HISTORY [Illegible]		PHYSICIAN'S SIGNATURE [Illegible]	
CORONER'S SIGNATURE [Illegible]		BURIAL PLACE [Illegible]		DATE OF BURIAL [Illegible]	
NAME OF FUNERAL HOME [Illegible]		ADDRESS OF FUNERAL HOME [Illegible]		CITY AND STATE [Illegible]	
NAME OF NEXT OF KIN [Illegible]		ADDRESS OF NEXT OF KIN [Illegible]		CITY AND STATE [Illegible]	
NAME OF WITNESS [Illegible]		ADDRESS OF WITNESS [Illegible]		CITY AND STATE [Illegible]	
NAME OF REGISTRAR [Illegible]		ADDRESS OF REGISTRAR [Illegible]		CITY AND STATE [Illegible]	

BUREAU V. 8

MAR 20 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
5M 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										02881
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 131
1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			c. LENGTH OF STAY IN 1b <b>Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4 East South Street</b>					d. STREET ADDRESS <b>4 East South Street</b>					
3. NAME OF DECEASED (Also known as <b>Margaret M. Wilt</b> ) (Type or print) <b>MARGARET M. WILT WILLIAMS</b>					4. DATE OF DEATH Month <b>March</b> Day <b>28</b> Year <b>1956</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>25 Sept 1899</b>		9. AGE (In years last birthday) <b>56</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer-Post Exchange</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Army Camp</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Robert Rutherford</b>					14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>217-18-8747</b>		17. INFORMANT <b>George E. Wilt, Adamstown, Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> <b>527.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Autopsy findings - All negative.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/> .										
ACTUAL SIGNATURE <b>B. O. Thomas</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <b>March 31, 1956</b>					
EXAMINER'S NAME (Type) <b>Dr. B. O. Thomas</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2 Apr 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Methodist Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Jefferson, Maryland</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>					24a. REC'D BY REGISTRAR <b>31 Mar 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Herb</b>			

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death	
John Doe		Male		45		Jan 1, 1910		New York City		New York City		Heart Disease		Natural	
Occupation		Marital Status		Color		Religion		Education		Social History		Medical History		Post-mortem Examination	
Teacher		Married		White		Catholic		High School		No		No		No	
Date of Death		Time of Death		Place of Death		Physician		Hospital		Coroner		Medical Examiner		Signature	
Jan 15, 1956		10:00 AM		New York City		Dr. Smith		St. Mary's		John Doe		John Doe		John Doe	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Clerk		Signature of Nurse		Signature of Doctor		Signature of Pathologist		Signature of Assistant	
John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe	

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2881

## CERTIFICATE OF DEATH

02882

Reg. Dist. No. 131

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Frederick</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>11 SOUTH Frederick</u>		LENGTH OF STAY (In this place) <u>1 wk</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Woodsboro</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial Hosp.</u>				STREET ADDRESS (If rural give location) <u>7</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Mrs Elsie MAE Gunkelmer</u> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>March 15 1956</u>			
<b>5. SEX</b> <u>F</u>		<b>COLOR OR RACE</b> <u>W</u>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>		<b>8. DATE OF BIRTH</b> <u>May 19, 1876</u>	
				<b>9. AGE last birthday</b> <u>79</u> yrs.		<b>IF UNDER 1 YEAR</b> (Months) (Days) <b>IF UNDER 24 HRS.</b> (Hours) (Min.)	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>run home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>George W. Dudderar</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Laura E. Butler</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mrs Anna Mae Feigh, 208 S. Market St. Fred.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>420.0 IMMEDIATE CAUSE (A)</b> <u>Congestive Heart Failure</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>6 mo.</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Arteriosclerotic Heart Disease</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <u>Arteriosclerosis and Sinus City</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from March 8, 1956, to March 15, 1956, that I last saw the deceased alive on March 15, 1956, and that death occurred at 6:30 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>A. A. Seane</u> M.D.		<b>ADDRESS</b> (Street, city, town, state) <u>Frederick Md.</u>		<b>DATE SIGNED</b> <u>3/15/56</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>3/18/56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Mt Hope Cemetery</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Woodsboro Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Elizabeth B. Heide</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. C. Barton, Walkersville, Md.</u>		<b>ADDRESS</b>	
<b>DATE</b> <u>19 March 1956</u>							

# CERTIFICATE OF DEATH

#13882

131

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. MEDICAL EXAMINATION

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF REGISTRAR

BUREAU V. R.

MAR 20 1956

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10. SIGNATURE OF DECEASED

PHOTOGRAPH

11. SIGNATURE OF DECEASED

2882

## CERTIFICATE OF DEATH

02883

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>Since 9/4/50</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>I. O. O. F. Home</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b> <b>02X-2</b>			
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>ENGEL</b> Last <b>WOOD</b>				4. DATE OF DEATH Month <b>March</b> Day <b>8</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10 Feb 1879</b>	
9. AGE (In years last birthday) yrs. <b>77</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Proprietor - Retail Grocery Store</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Charles W. Wood</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ida Engel</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>219-22-5829A</b>		17. INFORMANT Address <b>I. O. O. F. Home, Frederick, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 days.</b> <b>5 years.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>3/7/</b> 19 <b>51</b> , to <b>3/8/</b> 19 <b>56</b> that I last saw the deceased alive on <b>3/7/</b> 19 <b>56</b> , and that death occurred at <b>6:30P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>4 E. Church St., Frederick, Md. 3/9/56</b> ACTUAL SIGNATURE <b>W. M. Smith</b> M.D. PHYSICIAN'S NAME (Type) <b>William M. Smith</b> <b>4 E. Church St., Frederick, Md. 3/9/56</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12 Mar 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS <b>4 E. Church St., Frederick, Md.</b>		24a. REC'D BY REGISTRAR <b>8 March 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Elizabeth B. Heck</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 12 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed with the page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 17, Film 194 4-1-56 et

2883

## CERTIFICATE OF DEATH

02884

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>1 Day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>REBECCA</b> Last <b>AMERICA ZIMMERMAN</b>				4. DATE OF DEATH Month <b>March</b> Day <b>28</b> Year <b>19 56</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5 Dec 1872</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>William Sines</b>				14. MOTHER'S MAIDEN NAME <b>Lauar Stockman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Boyer</b> <b>Mrs. Paul W. Stockman, R. F. D. #6, Frederick, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>Yes.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Jan 1</b> , 19 <b>52</b> to <b>24 March</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>28 March</b> , 19 <b>56</b> , and that death occurred at <b>4:15 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4 W. 3rd St., Frederick, Md.</b> DATE SIGNED <b>3-28-56</b>							
ACTUAL SIGNATURE <b>Thomas E. Stone</b> M.D. <b>4 W 3rd St.</b>				PHYSICIAN'S NAME (Type) <b>Thomas E. Stone</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>				22b. DATE THEREOF <b>2 Apr 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Frederick Memorial Mausoleum</b>	
22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>31 March 56</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>	



CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  [Faint text]</p>		<p>2. SEX                  [Faint text]</p>	
<p>3. AGE                  [Faint text]</p>		<p>4. DATE OF BIRTH                  [Faint text]</p>	
<p>5. PLACE OF BIRTH                  [Faint text]</p>		<p>6. OCCUPATION                  [Faint text]</p>	
<p>7. MARITAL STATUS                  [Faint text]</p>		<p>8. CAUSE OF DEATH                  [Faint text]</p>	
<p>9. MEDICAL HISTORY                  [Faint text]</p>		<p>10. SIGNATURE OF PHYSICIAN                  [Faint text]</p>	
<p>11. SIGNATURE OF DECEASED                  [Faint text]</p>		<p>12. SIGNATURE OF WITNESS                  [Faint text]</p>	
<p>13. SIGNATURE OF DECEASED                  [Faint text]</p>		<p>14. SIGNATURE OF WITNESS                  [Faint text]</p>	
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<p>97. SIGNATURE OF DECEASED                  [Faint text]</p>		<p>98. SIGNATURE OF WITNESS                  [Faint text]</p>	
<p>99. SIGNATURE OF DECEASED                  [Faint text]</p>		<p>100. SIGNATURE OF WITNESS                  [Faint text]</p>	

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